

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

8788-62-035933

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

FILED SEP 17 1962

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY - - -		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY - - -	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in lb 20 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis - Little Rock Hospitals, Inc.		d. STREET ADDRESS (If outside, give location) 7020 Lansdowne Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Cecil Roy Boergadine		4. DATE OF DEATH Month Day Year September 9, 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-10-1897
9. AGE (last birthday) 65		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Sargent		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (City and state or country) St. Charles, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Patrick Henry Boergadine		13b. MOTHER'S MAIDEN NAME Nellie Clark	
14. NAME OF HUSBAND OR WIFE Mrs. Stella Boergadine		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. INFORMANT Mrs. Stella Mae Boergadine		Address 7020 Lansdowne	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO (b) Artial Fibrillation DUE TO (c) Multiple Emboli Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>
20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20e. TIME OF INJURY Hour a.m. p.m. Month, Day, Year August 21, 1962			
20f. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) August 21, 1962			
20g. CITY, TOWN, OR LOCATION St. Louis, Mo.			
20h. COUNTY St. Louis			
20i. STATE Missouri			
21. I attended the deceased from August 21, 1962, to September 9, 1962, and last saw her alive on Sept. 9, 1962. Death occurred at 1:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. Hoffmeister		22b. ADDRESS St. Louis, Mo.	
22c. DATE SIGNED 9-10-62		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Car	
23b. DATE 9-11-62		23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	
23d. LOCATION (City, town, or county) Tebbetts, Missouri		23e. STATE Missouri	
24. FUNERAL DIRECTOR C. Hoffmeister Mortuary - 6464 Chippewa		25. DATE REG. BY LOCAL REG. SEP 11 1962	
26. REGISTRAR'S SIGNATURE Karl Smith, M.D.		27. REGISTRAR'S SIGNATURE	

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John L. Dennehy

Licensed Embalmer No. _____
P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.